



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELLEN DUNCAN, MD

Respondent Name

TPCIGA FOR AMERICAN MOTORISTS

MFDR Tracking Number

M4-17-2295-01

Carrier's Austin Representative

Box Number 50

MFDR Date Received

MARCH 31, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In review of your explanation of benefits, it seems that you denied our code L8680. Please find enclosed office notes for review of claim. That this was done in the office."

Amount in Dispute: \$12,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TPCIGA supports the position statement provided by our medical review vendor Review Med, please see attached."

ReviewMed Position Summary: "On the original review of these charges, L8680 was denied. The denial reason stated we were requesting the purchase invoice for the implantables. Given the amount billed for L8680, the invoice is used to support the item and quantity billed as well as ensuring a valid payment is reimbursed. The requestor submitted a request for reconsideration but the request did not include the purchase invoice for the implantables. The invoice was also not included with the MDR request."

Response Submitted by: Texas Property & Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2016	HCPCS Code L8680(16) Implantable Neurostimulator Electrode, Each	\$12,000.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for

professional services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Please identify the supply and submit with a copy of the invoice for our review.
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3-Code description not listed.

Issues

Is the respondent's denial of payment for HCPCS code L8680 (X16) supported? Is the requestor entitled to reimbursement?

Findings

28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

On the disputed date of service, the requestor billed codes 63650, S0020, L8680, J2704, J2250 and 99144. The respondent paid codes 63650, J2250, J2704, and 99144. Only code L8680 is in dispute.

The respondent denied reimbursement for HCPCS code L8680 based upon reason code "16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

HCPCS code L8680 is defined as "Implantable neurostimulator electrode, each." The requestor billed for 16 units of code L8680.

Based upon the submitted medical bill the services were rendered in place of service code "11-Office."

Per CMS Medicare Claims Processing Manual Publication 100-04, Change Request 8645, Section (I) titled General Information, Subsection (B) Policy, under the heading Specific Coding and Pricing Issues "As part of this update, effective April 1, 2014, HCPCS code L8680 is not included on the 2014 DMEPOS fee schedule file and the coverage indicator is revised to not payable by Medicare ("I). For neurostimulator devices, HCPCS code L8680 is no longer separately billable for Medicare because payment for electrodes has been incorporated in CPT code 63650 Percutaneous implantation of neurostimulator electrode array, epidural. CMS established non-facility practice expense inputs for CPT code 63650 in the Medicare Physician Fee Schedule Final Rule (published November 27, 2013). As a result, practitioners should not report electrode(s) using code L8680 in conjunction with a lead implantation procedure furnished in any setting for Medicare."

The requestor billed and was paid at the non-facility rate \$4,017.84 for procedure code "63650-Percutaneous implantation of neurostimulator electrode array, epidural".

Based upon Medicare policy, HCPCS code L8680 is no longer billable in the office or non-facility setting because it is included in the payment for procedure code 63650: therefore, the respondent's denial of payment is supported and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	4/20/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.